Williston Center

Lifestyle Enhancement Request Form

DATA PRIVACY: You are being asked to provide data about yourself that is classified as private. The data will be used determine whether Williston will require physician approval before you begin an exercise program, and to assist in determining what programs or activities will be recommended to you. You are not required to supply the data that has been requested, but if you refuse to provide the information, you may not be allowed to participate in programs or activities. Depending upon the nature of the information provided, Williston may require physical approval before allowing you to participate in a program or activity. The information that you provide will be shared with city employees or contracting parties whose job duties require access, with the city's insurance carrier in the event of injury, and with those persons who you consent to have access.

Date:_____ Name:_____ID: _____

Phone:_____ Email Address:_____

Are you a member of the Williston Fitness Center ❒ Yes ❒ No

Are you a City of Minnetonka employee? ❒ Yes ❒ No

What **Lifestyle Enhancement** service would you like to sign up for (circle)?

Personal Training Wellness Coaching Nutrition Consultation Fitness Assessment

Have you ever had any Williston Lifestyle Enhancement services before? ❒ Yes ❒ No
If yes, whom did you work with? _____

Do you prefer a male or female trainer? ❒ Male ❒ Female ❒ Either

Specific trainer requested? List name _____

What are your fitness goals (please be as specific as possible)? _____

_____

Are you interested in Individual or Group Training? ❒ Individual ❒ Group

Personal Training sessions are 1 hour in length. Please choose which package you are interested in: ❒ 1 Session ❒ 4 Sessions ❒ 8 Sessions ❒ 12 Sessions

When are you available to train? (Please check all that apply) – **Required**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
❒ 12pm - 2p	❒ 6am - 8am	❒ 6am - 8am	❒ 6am - 8am	❒ 6am - 8am	❒ 6am - 8am	❒ 9am - 10am
❒ 2pm - 4pm	❒ 8am - 10am	❒ 8am - 10am	❒ 8am - 10am	❒ 8am - 10am	❒ 8am - 10am	❒ 10am - 12pm
❒ 4pm - 6pm	❒ 10am - 12pm	❒ 10am - 12pm	❒ 10am - 12pm	❒ 10am - 12pm	❒ 10am - 12pm	❒ 12pm - 2pm
❒ 6pm - 8pm	❒ 12pm - 2pm	❒ 12pm - 2pm	❒ 12pm - 2pm	❒ 12pm - 2pm	❒ 12pm - 2pm	❒ 2pm - 4pm
	❒ 2pm - 4pm	❒ 2pm - 4pm	❒ 2pm - 4pm	❒ 2pm - 4pm	❒ 2pm - 4pm	❒ 4pm - 6pm
	❒ 4pm - 6pm	❒ 4pm - 6pm	❒ 4pm - 6pm	❒ 4pm - 6pm	❒ 4pm - 6pm	❒ 6pm - 8pm
	❒ 6pm - 8pm	❒ 6pm - 8pm	❒ 6pm - 8pm	❒ 6pm - 8pm	❒ 6pm - 8pm	❒ 8pm - 10pm
	❒ 8pm - 10pm	❒ 8pm - 10pm	❒ 8pm - 10pm	❒ 8pm - 10pm	❒ 8pm - 10pm	

Williston Center
Health History Questionnaire

Please respond to the following items as accurately as possible.
This information will be used by the evaluator to ensure a safe exercise environment.
All information will remain confidential unless further professional consultation seems warranted.

Home Address _____ **Phone** _____

City _____ **State** _____ **Zip**_____ **Email** _____

Work Address _____ **Work Phone**_____

City _____ **State** _____ **Zip**_____ **Title**_____

Date of Birth_____/_____/_____ **Age** _____ **Sex** ❒ M ❒ F _____

Individual to be contacted in the event of an emergency _____

Relationship to you _____ **Phone**_____

Address_____

Smoking Status

❒ Never Smoked
❒ Smoke only on occasion
❒ Smoke up to 1 pk/day
❒ Smoke up to 2 pk/day
❒ Smoke pipe/cigar only
❒ Ex-Smoker (how long_____)

Personal Physician _____ **Physician's Phone**_____

Do you have medical alert identification? ❒ Yes ❒ No *If yes, where is it located?* _____

_____

Please list all medications that you are currently taking.

Name of Drug	*Dosage/Frequency*	*Reason for Taking*

Please indicate if you have had, or presently have, any of the following:

- ❒ **Thyroid disorder**
- ❒ **Ankle swelling**
- ❒ **Epilepsy or seizures**
- ❒ **Diabetes**
- ❒ **Heart attack/heart disease**
- ❒ **Heart surgery**
- ❒ **Heart failure**
- ❒ **Heart murmur**
- ❒ **Heart valve disease**
- ❒ **Heart palpitations**
- ❒ **Chest pain**
- ❒ **Cancer**
- ❒ **Stroke**
- ❒ **Dizziness or fainting**
- ❒ **Unusual shortness of breath**
- ❒ **Chronic Bronchitis**
- ❒ **Emphysema**
- ❒ **Recent hospitalization**
- ❒ **Asthma**
- ❒ **Exercise-induced asthma**
- ❒ *Glucose intolerance*
- ❒ *Obesity*
- ❒ *High blood pressure*
- ❒ *High blood cholesterol*
- ❒ *High blood triglycerides*
- ❒ Phlebitis
- ❒ Hernia
- ❒ Back trouble
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Bone or joint problems
- ❒ Low blood pressure
- ❒ Hypoglycemia
- ❒ Hay fever/other allergies
- ❒ Emotional disorder
- ❒ Eating disorder
- ❒ Anemia
- ❒Other:_____

Are you, or may you be pregnant? ❒ Yes ❒ No

Describe any surgery that you have had within the last two years _____

_____

_____

Have you ever sustained any injury or experienced any type of chronic pain which has been diagnosed as due to physical activity or sports participation? ❒ Yes ❒ No

*If Yes, please explain*_____

_____

Has your weight fluctuated more than a few pounds? ❒ Yes ❒ No

*If Yes, please explain*_____

How long has it been since your last physical examination?

❒ Less than 1 year ❒ 1-2 years ❒ 2-3 years ❒ 3 or more years

What is your current cholesterol level? (Leave blank if you're not sure)

____Total ____LDL _____HDL ____Triglycerids

How often would you characterize your stress level as being high?

❒ Occasionally ❒ Frequently ❒ Constantly

Have any members of your immediate family been diagnosed with the following:

	Mother	Father	Sisters	Brothers	Grandparents
Heart disease	_____	_____	_____	_____	_____
Heart attack (under age 50)	_____	_____	_____	_____	_____
Heart surgery	_____	_____	_____	_____	_____
Stroke (under age 50)	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Pulmonary disease	_____	_____	_____	_____	_____
Sudden death	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____
Other:_____	_____	_____	_____		

I hereby state that all of the above information is accurate to the best of my knowledge.

Signature _____ Date _____

Exercise Status

Do you currently workout on a regular basis? ❒ Yes ❒ No

Is your occupation? ❒ Inactive (e.g., desk job) ❒ Light work (e.g., housework, light carpentry) ❒ Heavy work (e.g., heavy carpentry, lifting)

How often do you perform cardiovascular exercise for at least 20-30 minutes per session?
❒ No regular program ❒ 1 time/week ❒ 2 times/week ❒ 3-4 times/week ❒ 5 + times/week

How often do you weight train?
❒ No regular program ❒ 1 time/week ❒ 2 times/week ❒ 3-4 times/week ❒ 5 + times/week

Please indicate which weight lifting equipment you use: ❒ Free Weights ❒ Circuit Machines ❒ Body Weights

❒ **Starting Weight?**_____lbs **How many sets per muscle group?** ❒ 1-3 ❒ 4-6 ❒ 7+

How many repetitions? ❒ 4-6 ❒ 6-10 ❒ 8-12 ❒ 12-15 ❒ 15-20 ❒ >20

Which muscle groups are emphasized?
❒ Upper Back ❒ Lower Back ❒ Abdominals ❒ Chest ❒ Biceps ❒ Triceps
❒ Shoulders ❒ Hamstrings ❒ Calves ❒ Quads ❒ Other_____

Briefly describe your exercise program _____

Fitness Goals

Please indicate your *top three* fitness goals.

_____Improve strength
_____Improve muscle tone & shape
_____Improve cardiovascular fitness
_____Improve flexibility
_____Lose weight/decrease body fat
_____Gain weight
_____Improve diet/eating habits
_____Improve health
_____Reduce cholesterol
_____Reduce blood pressure
_____Increase energy
_____Reduce stress
_____Prevent injury
_____Rehabilitate injury
_____Train for a sports-specific event
_____Other_____

Exercise Preferences

How much time are you willing to devote to an exercise program?_____Min/Session _____Days/Week

On what days of the week would you like to exercise? S M T W Th F S

Mark the activities that you enjoy participating in or would like to try (choose up to 5).

❒ Aerobics
❒ Active gardening
❒ Backpacking
❒ Baseball/softball
❒ Bicycling
❒ Cross country skiing
❒ Dancing
❒ Downhill skiing
❒ Football
❒ Golfing
❒ Hiking
❒ Hockey
❒ Jogging/running
❒ Martial arts
❒ Mountain climbing
❒ Racquetball/handball
❒ Rollerblading
❒ Rope skipping
❒ Rowing
❒ Skating
❒ Soccer
❒ Stair/bench stepping
❒ Stretching
❒ Swimming
❒ Tennis
❒ Volleyball
❒ Walking
❒ Weight training
❒ Yoga
❒ Other_____

Nutrition Lifestyle

1. **What is your current weight?**_____lb _____kg **height?**_____ft. ____in.

2. **What would you like to weigh?**_____lb _____kg

3. **What is the most you ever weighed as an adult?**_____lb _____kg

4. **What is the least you ever weighed as an adult?**_____lb _____kg

5. **What weight loss methods have you tried?** _____

6. **Which do you eat regularly?**

❒ Breakfast ❒ Midmorning snack ❒ Lunch
❒ Midafternoon snack ❒ Dinner ❒ After-dinner snack

7. **How often do you eat out each week?** _____times

8. **What size portions do you normally have?**

❒ Small ❒ Moderate ❒ Large ❒ Extra large ❒ Uncertain

9. **How often do you eat more than one serving?**

❒ Always ❒ Usually ❒ Sometimes ❒ Never

10. **How long does it usually take you to eat a meal?** _____minutes

11. **Do you eat while doing other activities** (e.g., watching TV, reading, and working)**?** _____

12. **When you snack, how many times a week do you eat the following?**

_____Cookies, cake, pie	____Candy	_____Diet soda
_____Soft drinks	_____Doughnuts	_____Fruit
_____Milk or milk beverage	_____Potato chips, pretzels, etc.	_____Peanuts or other nuts
_____Ice cream	_____Cheese and crackers	____Other_____

13. **How often do you eat dessert?** _____times a day _____times a week

14. **What dessert do you eat most often?** _____

15. **How often do you eat fried foods?** _____ times a week

16. **Do you salt your food at the table?** ❒ Yes ❒ No

❒ Before tasting it ❒ After tasting it